PRINTED: 04/20/2012 FORM APPROVED OMB NO. 0938-0391

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL			
		15G100	B. WIN			04/04	/2012		
NAME OF	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP CODE				
			6371 VERMONT ST						
ARC OF	NORTHWEST INC	DIANA INC, THE		MERRILLVILLE, IN 46410					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ATE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
W0000									
			Wo	000					
	This visit was for	or a fundamental	'''						
		nd state licensure survey.							
		nd state neensure survey.							
	Date of Survey	: April 2, 3, and 4, 2012							
	Facility number	: 000638							
	Provider numbe								
	AIM number: 1								
	7 HIVI Hamber.	.00233770							
	Surveyor: Tim	Shebel, Medical Surveyor							
	1	ederal deficiencies also							
	reflect state find 460 IAC 9.	lings in accordance with							
	Ouality Review	completed 4/10/12 by							
	` '	d, Medical Surveyor III.							
		m, 1.10miour our roj or 111.							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		15G100	B. WIN	G		04/04/2	2012
	ROVIDER OR SUPPLIER			6371 VE	ADDRESS, CITY, STATE, ZIP CODE ERMONT ST LLVILLE, IN 46410		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	DECUMENCE NAMES CONDUCTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	I C	DATE
W0137	483.420(a)(12) PROTECTION Control facility must clients. Therefore that clients have appropriate persociothing. Based on observation facility failed to a clients (client #1) clothing two days. Findings include: Client #1 was obsort 4/2/12 from 4 and on 4/3/12 from 4 and on 4/3/12 from 4.M During both wore same blus weatshirt. Direct care staff a 4/3/12 at 7:34 A. stated, "He (client same clothes every stated of the same clothes every horizontal facility at 11:03 A 4/3/12 at 11:03 A 4/3/1	DF CLIENTS RIGHTS ensure the rights of all re, the facility must ensure the right to retain and use onal possessions and ation and interview, the assure 1 of 3 sampled) did not wear the same s in a row. : served at the group home :20 P.M. until 6:25 P.M., om 6:02 A.M. until 7:30 oth observations, client ue jeans and red #1 was interviewed on M Direct care staff #1 at #1) often wears the	W0		Client #1 has a new behavior public haddressed non-compliance. The plan will modified to address this specification to address this specification of type of non compliance. It will reviewed by his IDT, HRC and staff will be trained on modifications to BSP. Staff will also be trained on ensuring the all consumers wear clean clothing. Service Coordinator ensure staff training is complet (5/4/12). To ensure future compliance Service Coordinate will continue to monitor consumers at least weekly for days and at least bi-monthly thereafter.	be fic be I at will ted or	05/14/2012

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Event ID: DE3R11

Facility ID: 000638

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		1 1			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		15G100	B. WIN			04/04/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
400.05	NODEL IMPORTANT	IANA INO TUE			ERMONT ST	
	NORTHWEST INDI	IANA INC, THE		MERKI	LLVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
W0149	483.420(d)(1)	LSC IDENTIFYING INFORMATION)		TAG	DEI (CLERCT)	DATE
W0149	STAFF TREATM The facility must written policies a	MENT OF CLIENTS develop and implement and procedures that prohibit glect or abuse of the client.				
			W0	149	Service Coordinator will retrain	05/14/2012
	Based on record	review and interview, the			Program Specialist on	
		to implement their			documentation and reporting	
	abuse/neglect po	licy to show evidence of			requirements of injuries of unknowr origin and agency policy on abuse	1
	thorough investig	gation of 2 of 5 injuries			and neglect investigations.	
	of unknown origi	in which involved 2 of 5			(5/14/12)	
	clients living at t	he group home (clients			To ensure future compliance	
	#2 and #4) and re	eport findings to the			Program Specialist, Service	
	administrator wit	thin five bushiness days			Coordinator, Behavioral Health	
	for 1 of 5 injuries	s of unknown origin			Director, and/or Director of Nursing will monitor all incident reports to	
	which involved 1	of 3 sampled clients			assess need for investigation at leas	t
	(client #2).				weekly.	
	Findings include	:				
	1. The facility's	incident reports, from				
	9/1/11 to 4/2/12,	were reviewed on 4/2/12				
	·	ne review indicated the				
	following injury	of unknown origin				
	involving client #	#2: "Date: 1-21-12,				
	Name: [Client #	2], Brief Description: I				
	(direct care staff	#7) went to check on				
	guys (clients #1,	#2, #3, #4, and #5.)				
	[Client #2] was t	rying to get out of [client				
	#3's] room. I tur	ned on hallway light &				
	saw [client #2's]	face was bruised &				
	scraped. I cleane	ed & put antibiotic on his				
		this Incident/Accident: "I				
	(direct care staff	#7) am not certain what				
	caused his (client	t #2's) injuries." The				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G100	B. WIN			04/04/	2012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL IMPORTANT	IANA INO THE			ERMONT ST		
	NORTHWEST INDI			MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
TAG			+	IAU			DATE
		ursory investigation, dicated "Client (client #2)					
		, ,					
	I -	t of another client's bed ches & abrasions to L					
		face. Staff cleaned area					
	` ′	Further review of the					
		e" of the investigation					
		ijuries failed to show					
		the facility concluded					
		es were caused by					
		•					
	crawling on the floor to get to his own bed. The outcome into the investigation						
		cident further indicated					
		ninistrator was not					
	I	outcome" of the cursory					
	investigation unt	· ·					
	investigation unt	11 1/30/12.					
	Nurse #1 was int	terviewed on 4/3/12 at					
		rse #1 indicated direct					
		y put client #2 in the					
	· ·	se #1 further indicated					
		the incident but failed to					
		ment her findings and					
	also indicated the	_					
		o the 1/21/12 incident					
		le to the administrator					
	until 1/30/12.	to the administrator					
	2. The facility's	incident reports, from					
		were reviewed on 4/2/12					
		ne review indicated the					
		of unknown origin					
	" " "	#4: "Date: 1/13/12,					
	ı	4], Brief Description:					
		., Brief Beseription.					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G100		LDING	NSTRUCTION 00	(X3) DATE COMPL 04/04 /	ETED
	PROVIDER OR SUPPLIER		p. wiiv	STREET A	DDRESS, CITY, STATE, ZIP CODE ERMONT ST LVILLE, IN 46410	•	
(X4) ID PREFIX	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E	(X5) COMPLETION
PREFIX TAG	REGULATORY OR [Client #4] came red and swollen a shot. Staff (direct about 2 hrs later gone down and the Could have been something." Cat Incident/Accident have it when he can morning but return after a couple of follow up report indicated the caus swollen face and follows: "Client (history) of season the eyes & swell within two hours required." Furth conclusion, of the nurse as follows: himself on the nucleaned area with oint (ointment.)" investigation into failed to show even investigation and cause client #4's blood shot eye.	home with his left cheek and his eye was blood et care staff #8) checked and it (swelling) had he redness went away. reaction (sic) to use of this et: "Unknown - did not (client #4) left this rned with it. Went away hours." A 1/19/12 by the program specialist se of client #4's red and bloodshot eye as (client #4) has hx onal allergies, Redness in ing of the cheek subsided et. No treatment er review indicated a le same incident, by the "Client (client #4) cut ose while shaving. Staff in Peroxide & and applied Further review of the othe 1/13/12 incident ridence of a thorough I what the one possible red, swollen face and		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION DATE
	10:52 A.M Nu unaware of anoth	erviewed on 4/3/12 at rse #1 indicated she was her conclusion by the st. Nurse #1 further					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G100			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/04/2012			
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP CODE 6371 VERMONT ST MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
		vestigated the incident but the ship document her						
	reviewed on 4/4. Review of the fa Handling Cases dated 12/20/200 following: "III.	cords were further /12 at 10:40 A.M cility's "Policy for of Neglect and Abuse", 6, indicated, in part, the All allegations will be the facility's investigation						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G100			ULTIPLE CO LDING	00	COMPL	ETED	
		15G100	B. WIN	G		04/04/	2012
	PROVIDER OR SUPPLIER NORTHWEST INDI			6371 VI	ADDRESS, CITY, STATE, ZIP CODE ERMONT ST LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
W0154	The facility must alleged violations. Based on record facility failed to thorough investig of unknown injuritiving in the grou #4). Findings include 1. The facility's 9/1/11 to 4/2/12, at 1:34 P.M The following injury involving client # (direct care staff guys (clients #1, [Client #2] was the #3's] room. I turnsaw [client #2's] scraped. I cleane face." Cause of (direct care staff caused his (client "outcome" of a condated 1/30/12 indicated the part of the face." The following injury involving client #2's] scraped. I cleane face. "Cause of (direct care staff caused his (client "outcome" of a condated 1/30/12 indicated the face." The following out and caused scrate (left) side of his state of the face."	have evidence that all sare thoroughly investigated. review and interview, the assure evidence of a gation for 2 of 5 injuries ries for 2 of 5 clients up home (clients #2 and : incident reports, from were reviewed on 4/2/12 the review indicated the of unknown origin #2: "Date: 1-21-12, 2], Brief Description: I #7) went to check on #2, #3, #4, and #5.) rying to get out of [client ned on hallway light & face was bruised & this Incident/Accident: "I #7) am not certain what the this injuries." The ursory investigation, dicated "Client (client #2) to of another client's bed ches & abrasions to L face. Staff cleaned area Further review of the	W0	154	All staff will be retrained on documentation and reporting requirements of injuries of unknow origin, and agency policy on abuse and neglect investigations. (5/14/12). To ensure future compliance Program Specialist, Service Coordinator, Behavioral Health Director, and/or Director of Nursin will monitor all incident reports to assess need for investigation at leas weekly.	g	05/14/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G100	B. WING			04/04/	2012
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INC	DIANA INC, THE			ERMONT ST LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		me" of the investigation					
		injuries failed to show					
		v the facility concluded ies were caused by					
	1	floor to get to his own					
	bed.	noor to get to his own					
	bea.						
	Nurse #1 was in	nterviewed on 4/3/12 at					
		urse #1 indicated direct					
		ty put client #2 in the					
		rse #1 further indicated					
		I the incident but failed to					
	1	ument her findings.					
	2. The facility's	s incident reports, from					
	1	, were reviewed on 4/2/12					
		The review indicated the					
	following injury	y of unknown origin					
	involving client	#4: "Date: 1/13/12,					
	Name: [Client:	#4], Brief Description:					
	[Client #4] cam	e home with his left cheek					
	red and swollen	and his eye was blood					
	shot. Staff (dire	ect care staff #8) checked					
	about 2 hrs late	er and it (swelling) had					
	gone down and	the redness went away.					
		n reaction (sic) to					
	something. " C						
		ent: "Unknown - did not					
		(client #4) left this					
	1	urned with it. Went away					
	_	f hours." A 1/19/12					
		t by the program specialist					
		use of client #4's red and					
	swollen face and	d bloodshot eye as					

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTR A. BUILDING	00	COMPLETED
	15G100	B. WING		04/04/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	6371 VERM	RESS, CITY, STATE, ZIP CODE MONT ST ILLE, IN 46410	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	follows: "Client (client #4) has hx (history) of seasonal allergies, Redness in the eyes & swelling of the cheek subsided within two hours. No treatment required." Further review indicated a conclusion, of the same incident, by the nurse as follows: "Client (client #4) cut himself on the nose while shaving. Staff cleaned area with Peroxide & and applied oint (ointment.)" Further review of the investigation into the 1/13/12 incident failed to show evidence of a thorough investigation and what the one probable cause of client #4's red, swollen face and blood shot eye. Nurse #1 was interviewed on 4/3/12 at 10:52 A.M Nurse #1 indicated she was unaware of another conclusion by the program specialist. Nurse #1 further indicated she investigated the incident but failed to thoroughly document her findings. 9-3-2(a)			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15G100	B. WIN	G		04/04/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ERMONT ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0156	The results of all reported to the a representative or accordance with days of the incide		W0	156	The Behavioral Health Directo Service Coordinator or delega	*	05/04/2012
		review and interview, the			professional staff shall review		
	1	notify the administrator			incident/accident reports to		
		rvestigation into 1 of 5			assess the need for		
	1	ries of unknown origin			investigations. An investigator		
		of 5 clients living in the			be assigned when required. Up completion, the investigation s		
	group home (clie	ent #4).			be provided to the responsible		
	to 4/2/12, were referenced to 4/2/12, were refer	ident reports, from 9/1/11 eviewed on 4/2/12 at review indicated the of unknown origin #2: "Date: 1-21-12, 2], Brief Description: I #7) went to check on #2, #3, #4, and #5.) rying to get out of [client ned on hallway light & face was bruised & ed & put antibiotic on his this Incident/Accident: "I #7) am not certain what t #2's) injuries." The ursory investigation, dicated "Client (client #2) t of another client's bed			administrator. (5/4/12) To ensure future compliance to Service Coordinator and Behavioral Health Director shareview all incidents to assess to need for investigations. Investigations will be complete as required.	ne III he	

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	of Correction identification number: 15G100	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 04/04	LETED
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	6371 VI	ADDRESS, CITY, STATE, ZIP CO ERMONT ST LLVILLE, IN 46410	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	and caused scratches & abrasions to L (left) side of his face. Staff cleaned area with Peroxide." The results of the investigation of the 1/21/12 incident further indicated the facility's administrator was not notified of the "outcome" of the cursory investigation until 1/30/12. Nurse #1 was interviewed on 4/3/12 at 10:52 A.M Nurse #1 indicated direct care staff on duty put client #2 in the wrong bed. Nurse #1 further indicated the results of the investigation into the 1/21/12 incident were not available to the administrator until 1/30/12. 9-3-2(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	LDING	00	COMPL	ETED
		15G100	A. BUII B. WIN			04/04/	/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER	6371 VERMONT ST				
ARC OF	NORTHWEST IND	DIANA INC, THE	MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
W0441	483.470(i)(1) EVACUATION The facility must varied condition Based on record facility failed to for 4 of 4 client (clients #1, #2, night hours. Findings includ The facility's eval/1/11 to 4/2/12 at 1:48 P.M Tindicate clients participated in ever night shift. A.M., during the Area Manager #4/3/12 at 12:14 stated, "We did	DRILLS st hold evacuation drills under ns. I review and interview, the conduct evacuation drills s living at the facility #3, and #4) during over	WO		The Area Manager will retrain Dire Support Professionals on the timeframes for the different shifts required by the evacuation drills. Training is to include varying the time of the evacuation drills and making sure that the time of the dis clearly within the shift required, paying special attention to the timeframes at the end of the third shift and the beginning of the first shift. The Area Manager will be present for the first evacuation dri after retraining to insure that all staff are informed and able to carr out the necessary evacuation drills (5/14/12) To insure future compliance the Area Managers will monitor evacuation drills twice per month three months, then at least month thereafter. The tracking system for monitoring evacuation drills will be reviewed monthly to insure timeliness of training and drill.	as rill y for	05/14/2012

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